MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Vono P.O. Box 15640 Fort Worth, TX 76119	MDR Tracking No.: M4-04-1292-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TIG Insurance Co. P.O. Box 152870 Irving, TX 75039 BOX 28	Date of Injury: Employer's Name: YMCA of Metropolitan Forth Worth Insurance Carrier's No.: 000770000748690001

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/30/03	04/30/03	Prescription Medicine	$231.92	$231.92

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated October 20, 2003 states in part, "…The expected out come of this issue is that we feel the claims should be paid per Rule 134.503(a)(2)(A). In accordance with the Rule, the following formula shall be utilized for generic medications: AWP x number of units x 1.25 + $4.00 = MAR. In this case the patient received 120 pills the AWP based off the NDC# (58809042405) for the Carisoprodol dispensed is 328.96 x 1.25 + $4.00 = 412.20. Therefore, reimbursement should be $415.20 not the $183.28 the Carrier paid…"

PART IV: RESPONDENT'S POSITION SUMMARY

The insurance carrier or their representative did not respond to the TWCC-60 or the additional information.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- Carisoprodol, NDC # 58809042405 for date of service 04/30/03 denied as "M – Charge for this procedure exceeds average wholesale price plus mark-up". The requestor billed $415.20; the insurance carrier paid $183.28 leaving a disputed balance of $231.92. Per Rule 134.503(a)(2)(A) and *Red Book* Database Services the AWP is $1,370.65 ÷ 500 = $2.75 x 120, pills dispensed, = $330.00 x $1.25 = $412.50 + $4.00 = $416.50; therefore additional reimbursement in the amount of $231.92 is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $**231.92**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Marguerite Foster	02/11/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____